

Patient's Name: _____ Phone No.: () _____
(Last, First, M.I.)
Address: _____ Hospital: _____ Patient Chart No.: _____
(Number, Street, City, State) (Zip Code)

DETACH HERE - Patient identifier information is not transmitted to CDC

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

NATIONAL BACTERIAL MENINGITIS AND BACTEREMIA CASE REPORT



Form Approved OMB No. 0920-0009

1. STATE: (Residence of Patient) (1-2)		2. COUNTY: (Residence of Patient) (3-12)		5. HOSPITALIZED? (25) (If YES, date of admission)	
3. STATE I.D.: (13-18)		4. CDC I.D.: (19-24)		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No (26-31)	
6. DATE OF BIRTH: (32-37) Mo. Day Yr.		7a.) AGE: (38-39) Mo. Day Yr.		b.) Is age in day/mo/yr? (40) 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	
				c.) If <6 years of age is patient in daycare? (41) 1 <input type="checkbox"/> Yes (Daycare is defined as a supervised group of 2 or more unrelated children for >4 hours/week). 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	
				8. SEX: (42) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	
9a. RACE: (43) 1 <input type="checkbox"/> White 3 <input type="checkbox"/> American Indian/ Alaskan Native 9 <input type="checkbox"/> Not Specified 2 <input type="checkbox"/> Black 4 <input type="checkbox"/> Asian/Pacific Islander		9b. ETHNIC ORIGIN: (44) 1 <input type="checkbox"/> Hispanic 2 <input type="checkbox"/> Non-Hispanic		10. OUTCOME: (45) 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown	
				11. PHYSICIAN'S NAME:	
12. TYPE OF INFECTION CAUSED BY ORGANISM: (Check all that apply) 1 <input type="checkbox"/> Primary Bacteremia (46) 1 <input type="checkbox"/> Cellulitis (50) 1 <input type="checkbox"/> Septic arthritis (54) 1 <input type="checkbox"/> Meningitis (47) 1 <input type="checkbox"/> Epiglottitis (51) 1 <input type="checkbox"/> Conjunctivitis (55) 1 <input type="checkbox"/> Otitis media (48) 1 <input type="checkbox"/> Peritonitis (52) 1 <input type="checkbox"/> Other (specify) (56) 1 <input type="checkbox"/> Pneumonia (49) 1 <input type="checkbox"/> Pericarditis (53) (57-58)				13. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:* (59) (Check one) 1 <input type="checkbox"/> <i>Neisseria meningitidis</i> 5 <input type="checkbox"/> <i>Streptococcus pneumoniae</i> * (pneumococcus) 2 <input type="checkbox"/> <i>Haemophilus influenzae</i> 8 <input type="checkbox"/> Other Bacterial Species* (Specify: include mycobacteria, fungi) 3 <input type="checkbox"/> Group B streptococcus 4 <input type="checkbox"/> <i>Listeria monocytogenes</i> *(Report ONLY CSF Isolates (60-61) for Pneumococcus or Other Bacterial Species)	
14. SPECIMEN FROM WHICH ORGANISM ISOLATED: (Check all that apply) 1 <input type="checkbox"/> Blood (62) 1 <input type="checkbox"/> Pleural Fluid (64) 1 <input type="checkbox"/> Pericardial Fluid (66) 1 <input type="checkbox"/> Placenta (68) 1 <input type="checkbox"/> CSF (63) 1 <input type="checkbox"/> Peritoneal Fluid (65) 1 <input type="checkbox"/> Joint (67) 1 <input type="checkbox"/> Other Normally Sterile Site (69) (specify) (70-71)				15. DATE FIRST POSITIVE CULTURE OBTAINED: (Date Specimen Drawn) Mo. Day Yr. (72-77)	

IMPORTANT - PLEASE COMPLETE FOR THE FOLLOWING ORGANISMS:

HAEMOPHILUS INFLUENZAE**16a. Did patient receive *Haemophilus b* vaccine?** (78) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown If YES, Please Complete the List Below.

DOSE	DATE GIVEN	VACCINE NAME/MANUFACTURER	LOT NUMBER
	Mo. Day Yr.		
1	(79-84)	(85)	(86-95)
2	(96-101)	(102)	(103-112)
3	(113-118)	(119)	(120-129)
4	(130-135)	(136)	(137-146)

16b. What was the serotype? (147)

1 ☐ Type b 9 ☐ Not Tested or Unknown
2 ☐ Not Typable 8 ☐ Other
(Specify) _____
(148-149)

16c. If *H. influenzae* was isolated from blood or CSF, was it resistant to:

Ampicillin (150) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or Unknown
Chloramphenicol (151) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or Unknown
Rifampin (152) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or Unknown

NEISSERIA MENINGITIDIS**17a. What was the serogroup?** (153)

1 ☐ Group A 4 ☐ Group Y 9 ☐ Unknown
2 ☐ Group B 5 ☐ Group W135 8 ☐ Other
3 ☐ Group C 6 ☐ Not groupable (Specify) _____
(154-155)

17b. If *N. meningitidis* was isolated from blood or CSF, was it resistant to:

Sulfa (156) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or Unknown
Rifampin (157) 1 ☐ Yes 2 ☐ No 9 ☐ Not tested or Unknown

(Please Print Clearly)

Submitted By: _____

Phone No.: () _____ Date: ____/____/____

Return completed report to:

Meningitis and Special Pathogens Branch
Mailstop C-09
National Center for Infectious Diseases
Centers for Disease Control and Prevention
Atlanta, GA 30333

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA; Hubert H. Humphrey Bldg., Rm. 737-F; 200 Independence Ave., SW; Washington, DC 20201, and to the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, DC 20503.